IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 5, 2007

Christopher Moore, Administrator
Assisted Living on Shamrock
9622 West Silverbirch Street
Boise, ID 83709

Dear Mr. Moore:

On September 13, 2007, a complaint investigation survey was conducted at Assisted Living on Shamrock. The facility was found to be providing a safe environment and safe, effective care to residents.

The enclosed form, stating no core issue deficiencies were cited during the survey, is for your records only and need not be returned.

Please bear in mind that non-core issue deficiencies were identified on the punch list, a copy of which was reviewed and left with you during the exit conference. The completed punch list form and accompanying evidence of resolution (e.g., receipts, pictures, policy updates, etc.) are to be submitted to this office by October 13, 2007.

Should you have any questions about our visit, please contact me at (208) 334-6626.

Sincerely,

JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/sc

Enclosure

IDAHO DEPARTMENT OF
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Assisted Living on Shamrock
9622 West Silverbirch Street
Boise, ID 83709

Dear Mr. Moore:

On September 13, 2007, a complaint investigation survey was conducted at Assisted Living on Shamrock. The survey was conducted by Sydnie Braithwaite, RN, Polly Watt-Geier, MSW, and Debra Sholley, LSW. This report outlines the findings of our investigation.

Complaint # ID00003049

Allegation #1: A resident had his dresser taken away to be given to another resident. The facility was not protecting his resident right to be treated with dignity and respect as the resident has no place to put his clothing and they were laid on the floor.

Findings: Based on observation and interview it could not be determined the resident was not treated with dignity and respect.

On September 13, 2007 at 11:00 a.m., the house manager stated the identified resident's sister was suppose to purchase a new dresser for the resident so she took the old dresser out of the room. " A month went by and she did not purchase the new dresser so I put the old one back in the room."

During tour of the facility on September 13, 2007 between 7:30 a.m. and 9:00 a.m., all of the residents at the facility had their own dresser and there were no clothes observed on the floors of the residents' rooms.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #2: The facility was not maintaining a safe and clean environment.

Findings: Based on observation and interview it was determined the facility did not maintain a safe and clean environment.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.550.a.iii for not protecting the residents' right to a safe and sanitary living environment. The facility was required to submit evidence of resolution within 30 days.

Allegation #3: The house manager was verbally abusive and intimidating towards the residents.

Findings: Based on observation and interview it could not be determined the house manager was verbally abusive and intimidating towards the residents.

On September 13, 2007 between 7:00 a.m. and 4:30 p.m., the house manager was not observed to be verbally abusive or intimidating towards residents.

On September 13, 2007 between 7:30 a.m., and 1:30 p.m., 4 random residents interviewed denied the house manager was verbally abusive and intimidating toward them.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #4. The facility had no activities planned.

Findings: Based on observation and interview it was determined the facility did not have planned activities for the residents.

On September 13, 2007 between 7:30 a.m., and 1:30 p.m., the house manager, facility owner, and 5 random residents interviewed confirmed the facility did not have planned activities.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.210 for not providing planned activities to the residents. The facility was required to submit evidence of resolution within 30 days.

Allegation #5: The facility was not following or implementing a resident's physician's orders.

Findings: Based on record review and interview it could not be determined the facility did not follow or implement an identified resident's physician orders.

The identified resident was no longer at the facility and therefore could not be interviewed.

The identified resident's medication administration records for the months of May and June 2007, documented the resident received his medications and treatments as ordered by the physician or authorized provider.

On September 13, 2007 at 11:00 a.m., the house manager stated the identified resident was able to do his own, "foot soaks." She stated sometimes she offered to help but the resident refused. Additionally, she stated, "If a resident has a physician's order to receive a daily medication then they get it daily."

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #6: The facility was not following their scheduled menus.

Findings: Based on record review and interview it was determined the facility did not follow the scheduled menu.

Conclusion: Substantiated. The facility was issued a deficiency at IDAPA 16.03.22.451.01.d for not following the scheduled menu. The facility was required to submit evidence of resolution within 30 days.

Allegation #7: The facility did not offer adequate amounts of food during meal times to the residents.

Findings: Based on interview it could not be determined the facility did not offer the residents adequate amounts of food during meal times.

On September 13, 2007 between 7:15 a.m., and 1:30 p.m., 4 random residents stated the facility offered adequate amounts of food during meal times.

On September 13, 2007 at 9:00 a.m., the house manager stated she always prepared plenty of food for each meal.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #8: The facility did not offer snacks to the residents between meal times.

Findings: Based on interview it could not be determined the facility did not offer the residents snacks between meal times.

On September 13, 2007 between 7:15 a.m., and 1:30 p.m., 4 random residents stated snacks were available between meal times.

On September 13, 2007 at 7:45 a.m., the house manager stated she always leaves snacks out for the residents.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #9: A resident was not supervised in his use of chewing tobacco, he spat on the carpet and onto the bathroom walls.

Findings: Based on interview and record review it could not be determined the identified resident was not supervised with his chewing tobacco.

The identified resident was away from the facility with family and therefore could not be interviewed.

Review of the identified resident's record on September 13, 2007, did not reveal any documented evidence the resident had been spitting his chewing tobacco in the facility.

On September 13, 2007 at 11:15 a.m., the house manager and administrator stated the identified resident's guardian had taken the chewing tobacco away in April or May 2007 because the resident had been swallowing it. Additionally, they stated the resident had not been spitting his chewing tobaccow for serveral years.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #10: The facility forced residents to attend day treatment when they were sick. The facility also forced a resident to attend day treatment when a psychiatrist ordered the resident not to attend.

Findings: Based on record review and interview it was determined the facility did not force the residents to attend day treatment when they were sick and it could not be determined a psychiatrist had ordered the identified resident not to attend day treatment.

Review of the identified resident's closed record on September 13, 2007, did not reveal an order from a psychiatrist which documented the resident was not to attend day treatment.

On September 13, 2007 between 7:15 a.m., and 1:30 p.m., 4 random residents stated the facility did not force them to attend day treatment when they felt ill.

On September 13, 2007 at 7:17 a.m., the house manager stated residents attended day treatment 3 to 5 days a week, but not all residents went to day treatment and they had a choice if they wanted to go or not. Additionally, she stated she was not aware of a time a psychiatrist had ordered a resident not to attend day treatment.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

Allegation #11: An identified resident's care needs were not being met as he was disabled and was not assisted with his mobility, shower, laundry, housekeeping.

Findings: Based on record review and interview it could not be determined the identified resident was not assisted with his care need and/or the care needs were not met.
The identified resident was no longer at the facility and therefore could not be interviewed.

The identified resident's record documented the resident required verbal prompts with mobility and showering. It also documented the resident needed verbal prompts and hands on assistance with laundry and housekeeping.

On September 13, 2007 at 10:37 a.m., the administrator stated the resident needed to be verbally prompted to complete tasks, but was able to do much of his activities of daily living on his own. The resident did need assistance with housekeeping and laundry; which was provided to the resident.

Conclusion: Unsubstantiated. Although it may have occurred, it could not be determined during the complaint investigation.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

Debbie Sholley, LSW

DEBBIE SHOLLEY, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DS/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program

IDAHO DEPARTMENT OF HEALTH & WELFARE

BUREAU OF FACILITY STANDARDS
P.O. Box 83720
Boise, ID 83720-0036
(208) 334-6626 fax: (208) 364-1888

ASSISTED LIVING
Non-Core Issues Punch List

Facility Name	Physical Address	Phone Number
Assisted Living on Shamrock	2716 Shamrock Ave.	(208) 465-5923
Administrator	**City**	**ZIP Code**
Christopher Moore	Nampa	83686
Survey Team Leader	**Survey Type**	**Survey Date**
Debbie Shelley	Complaint Investigation	9/13/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
1	210	The facility failed to provide planned activities.		
2	451.a.d	The facility did not serve the planned breakfast on 9/13/07. Instead, residents were served cold cereal with milk and nothing else.		
3	550.03.a.iii	The facility did not protect the residents' rights to a safe and sanitary living environment to include: room #3 had a broken window with sharp, jagged edges, a bent curtain rod, and several cobwebs around the windows; the bathroom linoleum was approximately 1/2 inch away from the wall and had gap cracks along the floor in front of the sink cabinet. The wood base-boards were bubbled and pulled away from the sink cabinet, and there was no exhaust fan.		

Response Required Date	Signature of Facility Representative	Date Signed
10/13/07		

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Facility Name	Physical Address	Phone Number
Assisted Living on Shamrock	2716 Shamrock Ave	(208) 465-5923
Administrator	**City**	**ZIP Code**
Christopher Moore	Nampa	83686
Survey Team Leader	**Survey Type**	**Survey Date**
Debbie Shalley	Complaint Investigation	9/13/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
	(cont)	In room #4 the screen was pushed out of the sleeping area and the WINDOW covered with cobwebs. The blinds in the north side of the room were bent and broken and the carpet had several black & brown stains. In the bathroom the window screen was sitting on the sink and window sill had several cobwebs. Mold was found on the North wall on top of the window sill and the entire ceiling. A four by two-foot section of dry wall was missing from behind the toilet.		
		Room #2 had black and brown carpet stains.		
		Room #1 had mold build-up on tub bench in shower enclosure & cold water handle was loose.		

Response Required Date	Signature of Facility Representative	Date Signed
10/13/07	CML	

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Debbie Shelley	Complaint Investigation	9/13/07

NON-CORE ISSUES

ITEM #	RULE # 16.03.22	DESCRIPTION	DATE RESOLVED	BFS USE
	(cont)	Garage door was not on its tracks and was propped and being held up by a black bar or pipe.		
		the closet containing toxic cleaning supplies was not locked.		

Response Required Date	Signature of Facility Representative	Date Signed
10/13/07		